STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004998	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTHCARE ASSOCIATES INC	16725 PINE RIDGE PASS LEO, IN 46765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a home health state licensure survey. Survey Dates: May 13-15, 2013 Facility Number: IN004998 Surveyor: Miriam Bennett, RN, BSN, PHNS Home Healthcare Associates Inc is in compliance with the Indiana rules for home health agency licensure 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN May 15, 2013	N 000		